

# EXHIBIT CG

## ATTACHMENT 1

(10.21.15 2015-FRA-295

ReqDEF683-719)

Facility Code:

EO Location:

Date of Occurrence:

Report Number:

FRA - FRACKVILLE

BMU 3A-1002

Oct 21 2015  
13:25:00

2015-FRA-00295

**EXHIBIT**Exhibit CG Attachment 1 -  
10.21.15 2015-FRA-295  
ReqDEF683-719**Current Status of Inmate(s) (including housing status, misconduct information, etc):**Inmate Name:  
WARREN EASLEYInmate #  
KA1544Age:  
29Inmate Type:  
INMATECustody LevelCurrent Housing StatusDate Received  
May 16 2011Offense  
ROBBERYSentence

4 years 9 months - 12 years 6 months

Minimum Date  
May 06 2015Maximum Date  
Feb 06 2023Misconduct #Medical Treatment Given

Evaluated by SCIF Medical RN Nigh

security concerns

**OCCURENCE DESCRIPTION (who, what, where, when, why & how)**

On the above date and time, Inmate Easley, Warren KA1544 expressed suicidal ideations while speaking with Corrections Counselor Marhelko. Lt. Albert was notified and began organizing escort staff for POC placement. During this time, Easley covered his door, became non-compliant with staff, and attempted to damage his cell. Lt. Albert attempted to gain Easley's compliance which was met with negative results. Lt. Albert organized a compliance team to remove Easley from the cell and place him in the restraint chair due to his suicidal ideations and non-compliance. The compliance team consisted of Labor Foreman S. Polifka, COI Evans, COI Flowers, COI Berger, and COI Scarpati (Camera Operator). Lt. Albert briefed the team and proceeded to BMU 3A-1002. Easley complied with all orders, was restrained and escorted to the BMU Camera Cell and was placed in the restraint chair. All restraints were checked and assessment completed by RN Nigh. Photographs were taken at this time. The team exited the area and a debriefing was conducted by Lt. Albert. The compliance team was deactivated and ordered to complete paperwork and be seen by Medical.

Notification To	Name (Org/Person)	Date/Time
Facility Manager	Supt. B. Tritt	Oct 21 2015 13:45:00
Other	DSFM G. Miller	Oct 21 2015 13:45:00
Other	Major B. Keller	Oct 21 2015 13:45:00

**Weapon Information:** Was a Weapon Used ☐ Yes ☒ No

Describe Weapon: N/A

Was Weapon Recovered: ☐ Yes ☒ No

Req 3-DEF000684

Where/how was weapon made/obtained:

N/A

Additional Information about Weapon(s) (if applicable)

N/A

**Staff Response/Action (including times, names/titles, etc)**StaffMedical Attention Given

security concerns

Date/Time of ActionDescription of Action

security concerns

Additional Comments**Investigative Information**

Internal Investigation



External Investigation

Investigator:Suspect Name:Type of Suspect:Additional Comments**Reporting Official / Official In Charge Notation(s)****Attachments**Type# AttachedComment

security concerns

Req 3-DEF000685

security concerns

Is this occurrence related to a previous occurrence? ☐ Yes ☒ NoReport Number: N/ATyped name/title of reporting official:

Lukashewski, Captain

Signature:Date:Typed name/title of official-in-charge:

Brenda Tritt, Superintendent

Signature:Date:

11-3-15



2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1325: Easley states he is suicidal and wishes to go to POC

1335: Easley refuses orders to be placed in POC and covers door and begins banging inside the cell

1400: Directed to assemble compliance team

1426: team briefed

1431: restraint chair notice read to inmate.

1433: restraints applied

1435: placed in chair and lap belt secured for transport to the BMU camera cell

1440: systematically secured in the restraint chair

1440: medical confirms capillary refill and photos are taken

1441: team exits cell

1445: debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

None

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

No known injuries at this time

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

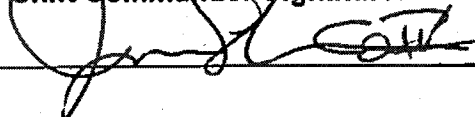
☐ No

☒ Yes

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):



10/21/15

2015-FRA-00295

☒ Use of Force Occurrence

To: Capt Lukashewski

Title: Shift Commander

Date: 10-21-15	Time: 1426
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From (Name Printed): Evans

**Title:** CO<sup>1</sup>

Location of Incident:  
BMY

**Employee Signature:**

Type of Incident: I/m chair placement

**Inmates Involved  
(Name and Number)**

**Staff Involved  
(Name and Title)**

## Witnesses

Easley, Warren KA1544

Let Albert video of Scarpa

CO<sup>+</sup> Flowers

(O' Brien)

LF Polifka

RN Nigh

1. Detailed description of the occurrence: On the above date and approx. Time this officer was assigned to a Compliance Team. I was assigned the ERID & Control I/m Eastley's KA1544 head. I took the restraint chair to cell 3A02 and assisted with escort of I/m to ISO Room. I controlled I/m Eastley's head while team <sup>TJE</sup> secured I/m. I left ISO room with no further incident. TJE



2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1426 Brief  
 1431 Team at Door 3A02  
 1433 Team enters 3A02  
 1438 ILM placed in restraint chair  
 1435 entered ISO Room  
 1441 ILM secured  
 1441 Med evaluation  
 1442 still photo's  
 1443 Team Exits ISO room  
 1445 debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

None

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

No known injuries at this time

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No ☒ Yes

SOARPATI Seculi

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):

10/21/15

2015-FRA-00295

☒ Use of Force Occurrence

Date: 10-21-15	Time: 1400
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Location of Incident:  
BMW

Type of Incident: chair placement

## Witnesses

Lt. Albert C. Scarpati  
 RN Nigh  
 CO Evans  
 CO Flannery  
 CO Berger

On the above date and time I Mr. Bliska was assigned to a compliance team in the BMU. I was assigned O.C. when on Cell door 3402 inmate easley complied with orders to be placed in restraint chair. I assisted in securing lap belt and Escorting inmate easley to BMU camera cell. I then assisted in placing inmate easley's arms and legs in restraint chair. At no time was O.C. used.

2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1420 Briefed  
 1431 on door  
 1433 cell open inmate seated in chair  
 1435 lap belt secured moved to camera cell  
 1441 straps secured, medical Evaluation  
 1442 still photos  
 1443 room Exits  
 1445 Debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

NONE

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

See medical reports

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No ☒ Yes

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):

*[Signature]*

10/21/15

2015 - FRA - 00295

☒ **Use of Force Occurrence**

1. Detailed description of the occurrence: In Above Dte & Approx Time  
This Officer Was In Charge Of The Video Camera In The Chair  
Placement Of Inmate KA1544 Foster, Warren. No Injuries  
To Staff Or Inmate To Report NEND OF REPORT N



2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1426 : Team Brief

1431 : At Door, Placed In Hand Cuffs

1433 : Door Opened

1433 : Shoulders Applied

1433 : Placed In Chair

1435 : Straps Secured (Wheelchair To ISO Room)

1435 : Entered ISO Room

1441 : Chair Secured / Straps Etc

1441 : Summon 134 Medical

1442 : Still Photos Taken

1443 : Team Exits ISO Room

1445 : Debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

NONE

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

NONE TO REPORT

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No ☒ Yes

Searpate Sub

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):

*[Signature]*

10/21/15

2015-FRA-0295

DC-121 Part 3 Revised 8/2012 Attachment C 6.3.1, Section 17		Pennsylvania Department of Corrections Employee Report of Incident		<input checked="" type="checkbox"/> Use of Force Occurrence	
To: <i>Capt. Lukashewski</i>		Title: <i>Shift Commander</i>		Date: <i>10/21/15</i>	
From (Name Printed): <i>J.W. Berger</i>		Title: <i>CO</i>		Time: <i>1400</i>	
Employee Signature: <i>J.W. Berger</i>		Location of Incident: <i>BMU</i>			
		Type of Incident: <i>Restraint Chair Placement</i>			
Inmates Involved (Name and Number)		Staff Involved (Name and Title)		Witnesses	
<i>Easley, Warren KA1544</i>		<i>Lt. Albert RN Nigh</i>			
		<i>CO Flowers</i>			
		<i>CO Evans</i>			
		<i>CO Scarpatti</i>			
		<i>LF Palitta</i>			
1. Detailed description of the occurrence: <i>On the above date and approximate time this officer was ordered to report to the BMU. This officer was then assigned to a compliance team for inmate Easley, Warren KA1544. This officer was assigned the leg restraints. Upon reaching 3A-02 cell inmate Easley was handcuffed and this officer secured the leg irons on the inmate. This officer then pushed the inmate in the restraint chair to the BMU camera room. This officer then assisted in securing the restraint straps for the arms and uncuffed the leg restraints.</i>					

2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1400 Ordered to report to the BMU  
 1426 Team briefed  
 1431 Team at door  
 1433 Team enters cell, secured restraints, placed in restraint chair  
 1435 Escorted in chair to camera room  
 1441 Straps secure. 3 Medical evaluation  
 1442 Still Photos  
 1443 Team Exits  
 1445 Team Debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

None

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

See Medical Reports.

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No

☒ Yes

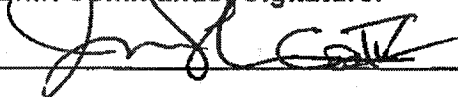
Scarpali

Sealy

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):



10/21/15

2015-FRA-00295

☒ Use of Force Occurrence

ON THE ABOVE DATE AND APPROXIMATE TIME THIS OFFICER WAS ASSIGNED TO A COMPLIANCE TEAM TO PLACE I/M ENSLEY INTO THE RESTRAINT CHAIR. I/M ENSLEY COMPLIED WITH ORDERS TO BE CUPPED. THIS OFFICER PLACED THE RESTRAINTS ON THE INMATE AND PLACED HIM INTO THE RESTRAINT CHAIR. I/M ENSLEY WAS ESCORTED TO THE CHAIR OBSERVATION ROOM AND THEN THIS OFFICER ASSISTED IN PLACING I/M ENSLEY INTO THE CHAIR AND REMOVING THE RESTRAINTS. AFTER THE INMATE WAS SECURE THIS OFFICER LEFT THE OBSERVATION ROOM WITHOUT FURTHER INCIDENT. - NOTHING FOLLOWS -



2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

1426: TEAM BRICKED

1431: TEAM IN DOOR

1433: TEAM ENTERED CELL 3A02. SHACKLES SECURED. SEATED IN CHAIR.

1435: STRAPS SECURED Transported to chair room

1441: STRAPS SECURE

1441: Medical eval

1442: Still Photos

1443: TEAM EXIT

1445: Debrief

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

NONE

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

NONE

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No ☒ Yes

Scarpale Scurly

Shift Commander Signature:

Date:

10/21/15

Tracking Number (If an attachment to a DC-121 Part 2):

2015-FRA-0295

☒ **Use of Force Occurrence**

**1. Detailed description of the occurrence:** Upon entering the BMU at 1330 to do an out of cell with inmate Smith, inmate Easley called me over to his cell I told him quickly I have a one on one to do he then became belligerent towards me and stated "I am suicidal and I need the time out cell, I need to talk to a psych or someone. I said ok, then I proceeded to enter the BMU bubble and alerted Lt. Albert that inmate Easley just told me he was suicidal. Lt. Albert and Lt. Reeder then left the control bubble and proceeded to talk to inmate Easley.

2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

I left the BMU block and entered the BMU control center and alerted LT. Albert the Inmate Easley stated he was suicidal.

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

None

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

None

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No

☐ Yes

Shift Commander Signature:

Date:

Tracking Number (If an attachment to a DC-121 Part 2):

*[Signature]*

10/21/15

2015-FRA-00295

☒ Use of Force Occurrence

Hugh  
[redacted] Nigh, RN



2. Actions taken (if force was used, include an account of the events prior to the use of force, the reason(s) for the use of force, and a description of the use of force. If any equipment was used (i.e., EBID, OC, etc.), describe the process, who authorized the equipment, who used the equipment and the effects of usage. (List all action taken in a chronological order.)

14210 Debriefing  
 1435 - placed in chain  
 1438 - medical assessment.

3. Description of any weapon(s) used by the inmate(s) or found in the area. If any, attach a photograph of the weapon(s).

none

4. Detailed description of any injuries sustained by staff and/or inmates and any medical attention provided.

none noted

Hing

Nigh, RN

If the occurrence involved a planned use of force, was the occurrence videotaped? If no, include an explanation in Section 2. If yes, include the camera operator's name and the custodian of the tape.

☐ No ☐ Yes

Shift Commander Signature:

Date:

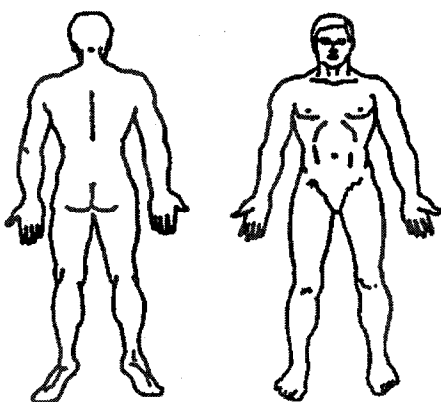
Tracking Number (If an attachment to a DC-121 Part 2):

*[Signature]*

10/21/15

Scarpati, Emily

2015-HA-00295

MEDICAL INCIDENT/INJURY REPORT					
<b>PERSON INVOLVED</b> (Last Name) <u>Easley</u> (First Name) <u>Warren</u> (Middle Initial)			Reported to Dispensary <u>Bmu</u> Date: <u>10/21/15</u> AM Time: <u>1435</u> PM		
Male: <input checked="" type="checkbox"/> Female: <input type="checkbox"/> Age: <u>28</u>					
Date of Incident <u>10-21-15</u>	Time of Incident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <u>1435</u>	Exact Location of Incident <u>Bmu</u>			
INMATE <input checked="" type="checkbox"/>	Facility No. <u>KA1544</u>	Housing Unit <u>Bmu</u>	Work Related Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
SUPERVISOR:					
EMPLOYEE <input type="checkbox"/>	Department		Job Title		
VISITOR <input type="checkbox"/>	Home Address		Home Phone		
OTHER <input checked="" type="checkbox"/>	Occupation		Reason for Presence at this Facility		
Property Involved: <input type="checkbox"/> Equipment Involved: <input type="checkbox"/> Describe: <u>restraint chain</u>					Was person authorized to be at location of incident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Describe exactly What Happened. Why it happened. Action Taken. If an Injury, State Part of Body Injured. If Property or Equipment Damaged, Describe Damage. 1. Description of Illness/Injury					
<u>Planned use of force to place inmate Easley KA1544</u> <u>in restraint chain to persecute inmate covered up cell and</u> <u>made suicidal statement</u>					
(Continue On Reverse)					
Was Physician Notified? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			Was Family Notified? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Was Person Involved Seen by a Physician? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date <u>/</u> <u>/</u> <u>NA</u>	Time <u>NA</u>	Where <u>NA</u>	Physician's Name <u>NA</u>
Was Person Involved Taken To A Hospital? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Date <u>/</u> <u>/</u> <u>NA</u>	Time <u>NA</u>	Where <u>NA</u>	By Whom <u>NA</u>
2. Initial Impression Illness/Injury <u>Physically calm</u> <u>BD hands capreful</u> <u>23000s. Radial pulses</u> <u>(+) skin warm &amp; dry</u> <u>BD feet pedal pulses</u> <u>present. Skin warm</u> <u>too touch normal for</u> <u>ethnicity. Visible open areas noted</u>			Indicate on Diagram Location of Injury		
TYPE OF INJURY 1. Laceration <input type="checkbox"/> 2. Hematoma <input type="checkbox"/> 3. Abrasion <input type="checkbox"/> 4. Burn <input type="checkbox"/> 5. Non Apparent <input checked="" type="checkbox"/> 6. Other <input type="checkbox"/> Specify _____					
3. Treatment Rendered: <u>Assessment in restraint</u>					
Follow-Up <u>for restraint chain policy</u>					
Date of Report <u>10/21/15</u>	Signature & Title of Person Preparing Report <u>Hugh RN</u> <u>Nigh, RN</u>			Reviewing Authority <u>Reg 3-DEF000703</u>	

**DISPOSITION AFTER TREATMENT**

1. Return to Block
  2. Place in RHU *Detrautchen* ☒
  3. Admit to Infirmary
  4. Admit to Community Hospital
  5. Return to work
  6. Refer to Physician Line
  7. Refer to Family Physician
  8. Refer to Community Hospital
- (Employee)

**DISTRIBUTION:**

Original: Medical File

Copies:

- Facility Manager
- Deputy for Facilities Management
- Deputy for Centralized Services
- Major(s)
- Security Officer
- Other

CONTINUED FROM REVERSE: (Items 1 through 3) (Indicate item).

## MEDICAL INCIDENT/INJURY REPORT

 PERSON INVOLVED (Last Name) Polifko (First Name) [REDACTED] (Middle Initial) [REDACTED]

 Reported to Dispensary  
 Date: 10/21/2015 AM  
 Time: 150 PM

 Male ☒ Female: ☐ Age: 32

 Date of Incident  
10-21-2015

 Time of Incident ☐ A.M. ☒ P.M.  
1430

 Exact Location of Incident: BMU

INMATE

Facility No.

Housing Unit

Work Related

Yes ☒No ☐

SUPERVISOR:

EMPLOYEE X

Department SecurityJob Title GOMaintenanceVISITOR ☐  
N/AHome Address N/AHome Phone N/AOTHER ☐Occupation N/AReason for Presence at this Facility N/A
 Property Involved: ☐ Equipment Involved: ☐ Describe: N/A

 Was person authorized to be at  
 location of incident:  
☒ Yes ☐ No

 Describe exactly What Happened. Why it happened. Action Taken. If an Injury, State Part of Body Injured. If Property or Equipment Damaged,  
 Describe Damage. 1. Discription of Illness/Injury

 Employee involved in planned use of force. & With Inmate Easley KA1544. Also  
placed in Restraint chair at this time.

(Continue On Reverse)

 Physician Notified? ☐ Yes ☒ NO

 Was Family Notified? ☐ Yes ☒ No

 Was Person Involved Seen by a Physician?  
☐ Yes ☒ No

Date Time A.M.

Where  
N/APhysician's Name  
N/A
 Was Person Involved Taken To Infirmary?  
 Yes ☐ No ☒
Date Time A.M.  
N/AWhere  
N/ABy Whom  
N/A

2. Initial Impression Illness/Injury

Employee ambulated to medical

 Department. Employee denies any  
 Injury at this time. No injuries

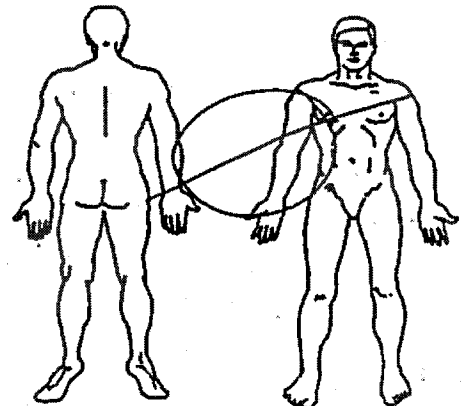
Noted at this time.

## TYPE OF INJURY

1. Laceration
- ☐
- 
2. Hematoma
- ☐
- 
3. Abrasion
- ☐
- 
4. Burn
- ☐
- 
5. Non Apparent
- ☒
- 
6. Other
- ☐

Specify \_\_\_\_\_

Indicate on Diagram Location of Injury


 3. Treatment Rendered: Employee assessed, instructed to report to Schuylkill Medical Center East ER/  
 Panel of Physicians if any injuries surface.

Follow-Up: Panel of physicians/SMC ER as needed

 Date of Report  
10/21/2015

Signature

[Signature]Thlroway, LPN

Reviewing Authority



## DISPOSITION AFTER TREATMENT

1. Return to Block \_\_\_\_\_
2. Place in RHU \_\_\_\_\_
3. Admit to Infirmary \_\_\_\_\_
4. Admit to Community Hospital \_\_\_\_\_
5. Return to work \_\_\_\_\_ X \_\_\_\_\_
6. Refer to Physician Line \_\_\_\_\_
7. Refer to Family Physician \_\_\_\_\_ (Employee)
8. Refer to Community Hospital \_\_\_\_\_

## DISTRIBUTION:

Original: Medical File

Copies: Facility Manager \_\_\_\_\_ X \_\_\_\_\_  
 Deputy for Operations \_\_\_\_\_  
 Deputy for Treatment \_\_\_\_\_  
 Major(s) \_\_\_\_\_  
 Security Officer \_\_\_\_\_  
 Other \_\_\_\_\_ X RNS \_\_\_\_\_

CONTINUED FROM REVERSE: (Items 1 through 3) (Indicate item).

MEDICAL INCIDENT/INJURY REPORT					
PERSON INVOLVED (Last Name) <u>Berger</u> (Middle Initial) <u>[REDACTED]</u>				Reported to Dispensary Date: <u>10/21/2015</u> AM Time <u>1230</u> PM	
Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Age: <u>28</u>					
Date of Incident <u>10-21-2015</u>		Time of Incident <u>1435</u> <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		Exact Location of Incident: <u>BMU</u>	
INMATE		Facility No. _____ Housing Unit _____		Work Related Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
SUPERVISOR: _____					
EMPLOYEE X		Department <u>Security</u>		Job Title <u>CO-I</u>	
VISITOR <input type="checkbox"/> N/A		Home Address <u>N/A</u>		Home Phone <u>N/A</u>	
OTHER <input type="checkbox"/>		Occupation <u>N/A</u>		Reason for Presence at this Facility <u>N/A</u>	
Property Involved: <input type="checkbox"/> Equipment Involved: <input type="checkbox"/> Describe: <u>N/A</u>				Was person authorized to be at location of incident: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Describe exactly What Happened. Why it happened. Action Taken. If an Injury, State Part of Body Injured. If Property or Equipment Damaged, Describe Damage. 1. Description of Illness/Injury					
Employee involved in planned use of force. <u>&amp; With Inmate Easley KA1544 Also placed in Restraint chair at this time.</u>					
(Continue On Reverse)					
Physician Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO		Was Family Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Person Involved Seen by a Physician? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date _____ Time _____ A.M. _____		Where <u>N/A</u> Physician's Name <u>N/A</u>	
Was Person Involved Taken To Infirmary? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Date <u>N/A</u> Time _____ A.M. _____		Where <u>N/A</u> By Whom <u>N/A</u>	
2. Initial Impression Illness/Injury		Indicate on Diagram Location of Injury			
Employee ambulated to medical		TYPE OF INJURY			
Department. Employee denies any Injury at this time. No injuries		1. Laceration <input type="checkbox"/> 2. Hematoma <input type="checkbox"/> 3. Abrasion <input type="checkbox"/> 4. Burn <input type="checkbox"/> 5. Non Apparent <input checked="" type="checkbox"/> 6. Other <input type="checkbox"/> Specify _____			
Noted at this time.					
3. Treatment Rendered: Employee assessed, instructed to report to Schuylkill Medical Center East ER/ Panel of Physicians if any injuries surface.					
Follow-Up: Panel of physicians/SMC ER as needed					
Date of Report <u>10/21/2015</u>		Signature <u>[Signature]</u> <u>Thiroway, LPN</u>		Reviewing Authority _____	

## DISPOSITION AFTER TREATMENT

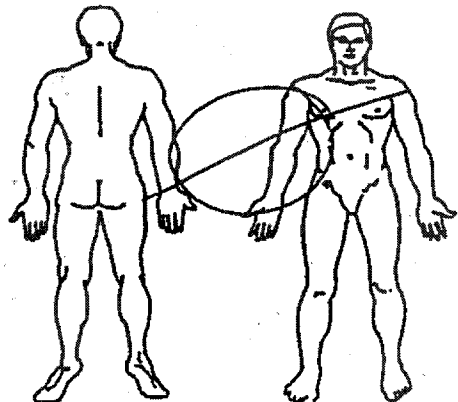
1. Return to Block \_\_\_\_\_
2. Place in RHU \_\_\_\_\_
3. Admit to Infirmary \_\_\_\_\_
4. Admit to Community Hospital \_\_\_\_\_
5. Return to work \_\_\_\_\_ X \_\_\_\_\_
6. Refer to Physician Line \_\_\_\_\_
7. Refer to Family Physician \_\_\_\_\_ (Employee)
8. Refer to Community Hospital \_\_\_\_\_

## DISTRIBUTION:

Original: Medical File

Copies: Facility Manager \_\_\_\_\_ X \_\_\_\_\_  
 Deputy for Operations \_\_\_\_\_  
 Deputy for Treatment \_\_\_\_\_  
 Major(s) \_\_\_\_\_  
 Security Officer \_\_\_\_\_  
 Other \_\_\_\_\_ X RNS \_\_\_\_\_

CONTINUED FROM REVERSE: (Items 1 through 3) (Indicate item).

MEDICAL INCIDENT/INJURY REPORT					
<b>PERSON INVOLVED</b> (Last Name) <u>Flowers</u> (Middle Initial) <u>[REDACTED]</u>				<b>Reported to Dispensary</b> Date: <u>10/21/2015</u> AM Time: <u>1:50</u> PM	
Male <input checked="" type="checkbox"/> Female: <input type="checkbox"/> Age: <u>27</u>					
Date of Incident <u>10-21-2015</u>		Time of Incident <u>1430</u> <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		Exact Location of Incident: <u>BMU</u>	
<b>INMATE</b>		Facility No. _____ Housing Unit _____		Work Related Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<b>SUPERVISOR:</b> _____					
<b>EMPLOYEE X</b>		Department <u>Security</u>		Job Title <u>CO</u>	
<b>VISITOR</b> <input type="checkbox"/> N/A		Home Address <u>N/A</u>		Home Phone <u>N/A</u>	
<b>OTHER</b> <input type="checkbox"/>		Occupation <u>N/A</u>		Reason for Presence at this Facility <u>N/A</u>	
Property Involved: <input type="checkbox"/> Equipment Involved: <input type="checkbox"/> Describe: <u>N/A</u>				Was person authorized to be at location of incident: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Describe exactly What Happened. Why it happened. Action Taken. If an Injury, State Part of Body Injured. If Property or Equipment Damaged, Describe Damage. 1. Discription of Illness/Injury					
Employee involved in planned use of force. <u>&amp; with Inmate Easley KA1544. Also placed in Restraint chair at this time.</u>					
(Continue On Reverse)					
Physician Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO		Was Family Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Person Involved Seen by a Physician? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date _____ Time _____ A.M. _____ P.M.		Where <u>N/A</u> Physician's Name <u>N/A</u>	
Was Person Involved Taken To Infirmary? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Date <u>N/A</u> Time _____ A.M. _____ P.M.		Where <u>N/A</u> By Whom <u>N/A</u>	
2. Initial Impression Illness/Injury		Indicate on Diagram Location of Injury			
Employee ambulated to medical		<b>TYPE OF INJURY</b> 1. Laceration <input type="checkbox"/> 2. Hematoma <input type="checkbox"/> 3. Abrasion <input type="checkbox"/> 4. Burn <input type="checkbox"/> 5. Non Apparent <input checked="" type="checkbox"/> 6. Other <input type="checkbox"/> Specify _____			
Department. Employee denies any Injury at this time. No injuries					
Noted at this time.					
3. Treatment Rendered: Employee assessed, instructed to report to Schuylkill Medical Center East ER/					
Panel of Physicians if any injuries surface.					
Follow-Up: Panel of physicians/SMC ER as needed					
Date of Report <u>10/21/2015</u>		Signature <u>[Signature]</u> <b>Thiroway, LPN</b>		Reviewing Authority _____	

## DISPOSITION AFTER TREATMENT

1. Return to Block \_\_\_\_\_
2. Place in RHU \_\_\_\_\_
3. Admit to Infirmary \_\_\_\_\_
4. Admit to Community Hospital \_\_\_\_\_
5. Return to work \_\_\_\_\_ X \_\_\_\_\_
6. Refer to Physician Line \_\_\_\_\_
7. Refer to Family Physician \_\_\_\_\_ (Employee)
8. Refer to Community Hospital \_\_\_\_\_

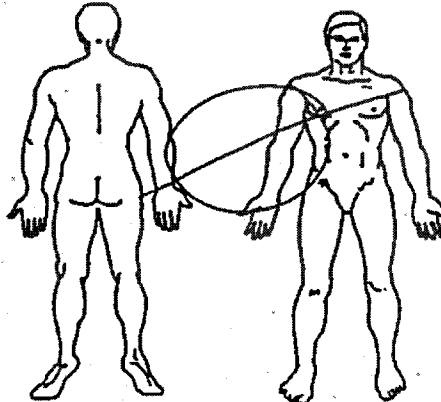
## DISTRIBUTION:

Original: Medical File

Copies: Facility Manager \_\_\_\_\_ X \_\_\_\_\_  
 Deputy for Operations \_\_\_\_\_  
 Deputy for Treatment \_\_\_\_\_  
 Major(s) \_\_\_\_\_  
 Security Officer \_\_\_\_\_  
 Other \_\_\_\_\_ X RNS \_\_\_\_\_

CONTINUED FROM REVERSE: (Items 1 through 3) (Indicate item).



MEDICAL INCIDENT/INJURY REPORT					
<b>PERSON INVOLVED</b> (Last Name) <u>EVANS</u> (Middle Initial) <u>[REDACTED]</u>				<b>Reported to Dispensary</b> Date: <u>10/21/2015</u> AM Time: <u>1:50</u> PM	
Male <input checked="" type="checkbox"/> Female: <input type="checkbox"/> Age: <u>38</u>					
Date of Incident <u>10-21-2015</u>	Time of Incident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <u>1430</u>	Exact Location of Incident: <u>BMU</u>			
INMATE	Facility No.	Housing Unit	Work Related Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
SUPERVISOR:					
EMPLOYEE X	Department <u>Security</u>		Job Title <u>CO</u>		
VISITOR <input type="checkbox"/> N/A	Home Address <u>N/A</u>		Home Phone <u>N/A</u>		
OTHER <input type="checkbox"/>	Occupation <u>N/A</u>		Reason for Presence at this Facility <u>N/A</u>		
Property Involved: <input type="checkbox"/> Equipment Involved: <input type="checkbox"/> Describe: <u>N/A</u>				Was person authorized to be at location of incident: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Describe exactly What Happened. Why it happened. Action Taken. If an Injury, State Part of Body Injured. If Property or Equipment Damaged, Describe Damage. 1. Discription of Illness/Injury					
Employee involved in planned use of force. <u>&amp; with Inmate Easley KA1544 Also placed in Restraint chair at this time.</u>					
(Continue On Reverse)					
Physician Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO		Was Family Notified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Person Involved Seen by a Physician? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date	Time	A.M.	Where <u>N/A</u>
Was Person Involved Taken To Infirmary? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Date <u>N/A</u>	Time	A.M.	Where <u>N/A</u>
Physician's Name <u>N/A</u>		By Whom <u>N/A</u>			
2. Initial Impression Illness/Injury		Indicate on Diagram Location of Injury			
Employee ambulated to medical		<div style="display: flex; align-items: center;"> <div style="flex: 1;"> <b>TYPE OF INJURY</b>            1. Laceration <input type="checkbox"/>            2. Hematoma <input type="checkbox"/>            3. Abrasion <input type="checkbox"/>            4. Burn <input type="checkbox"/>            5. Non Apparent <input checked="" type="checkbox"/>            6. Other <input type="checkbox"/>            Specify _____         </div> <div style="flex: 2; text-align: center;">  </div> </div>			
Department. Employee denies any Injury at this time. No injuries					
Noted at this time.					
3. Treatment Rendered: Employee assessed, instructed to report to Schuylkill Medical Center East ER/ Panel of Physicians if any injuries surface.					
Follow-Up :Panel of physicians/SMC ER as needed					
Date of Report <u>10/21/2015</u>	Signature <u>[Signature]</u> <u>Thiroway, LPN</u>			Reviewing Authority	

## DISPOSITION AFTER TREATMENT

1. Return to Block \_\_\_\_\_
2. Place in RHU \_\_\_\_\_
3. Admit to Infirmary \_\_\_\_\_
4. Admit to Community Hospital \_\_\_\_\_
5. Return to work \_\_\_\_\_ X \_\_\_\_\_
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7. Refer to Family Physician \_\_\_\_\_ (Employee)
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 Deputy for Treatment \_\_\_\_\_  
 Major(s) \_\_\_\_\_  
 Security Officer \_\_\_\_\_  
 Other \_\_\_\_\_ X RNS \_\_\_\_\_

CONTINUED FROM REVERSE: (Items 1 through 3) (Indicate item).

## Notice for Use of Restraint Chair

The Officer-in-Charge of the extraction will read this script to the inmate.

Inmate Easley Warren KA1544, I am LT Albert  
(name) (name and rank).

Date & Time: 10/21/15 1430

SCI: Frackville

Housing Unit: BMU

You are going to be placed into a restraint chair because : threats of self-harm and your failure to comply with orders to uncover your door and be placed in a POC cell.

This move is being videotaped. You will be handcuffed, tethered, and placed in leg irons. The officers who will secure you in the restraint chair will escort you. The length of time you remain in the restraint chair will depend on your behavior while you are in the chair.

Failure to comply with my orders or to cooperate with the officers assigned will result in the use of the minimum amount of force required to place you in the restraint chair. This use of force may include the use of the Electric Immobilizer Device (EID) and/or Oleoresin Capsicum (OC).

I am giving you a Direct Order to come to the door and place your hands out of the food panel to be handcuffed. (Repeat this order two more times, if necessary).



**Three Member Compliance Team Briefing Form**

Facility: Frackville Date: 10/21/2015  
 Time: 1426  
 DC-141#: \_\_\_\_\_

Inmate Name: Easley, Warren Inmate Number: KA1544

Situation: Inmate Easley made threats of self-harm, covered his cell door and loud banging was heard inside the cell. Easley refused all orders to uncover his door. All staff that attempted to gain his compliance were unsuccessful. Inmate Easley will be placed into the Restraint Chair.

Location: BMU 3A02

Defensive Weapons/Restraining Devices: OC, Ebid, Cuffs, Tether, Leg Irons, Restraint Chair

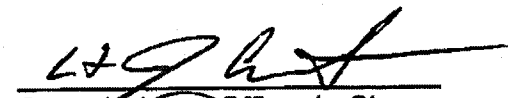
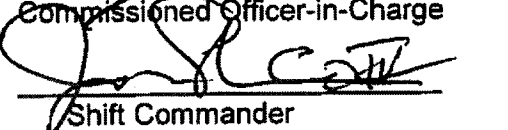
Medical Contacted before Use of Force (Time permitting) ☐ Yes ☐ No

Tools Required/Used: \_\_\_\_\_

**Three Member Compliance Team Officers:**

Team Member 1(Video Camera): CO Scarpati  
 Team Member 2(OC and gas mask): LF Polifka  
 Team Member 3(tether, handcuffs and gas mask): CO Flowers  
 Team Member 4(leg irons, and gas mask): CO Berger  
 Team Member 5(hand held EBID and gas mask): CO Evans  
 Commissioned Officer-in-Charge: LT Albert  
 Nurse/Medical Personnel: RN Nigh  
 Other Staff Present (Unit Manager, Counselor): \_\_\_\_\_

Notes: Extra officers were used on this compliance team to safely place inmate Easley in the Restraint chair

  
 Commissioned Officer-in-Charge  
  
 Shift Commander

10/21/15  
 Date  
10/21/15  
 Date

DC-709

# SECURITY LEVEL 5 HOUSING UNIT INMATE ACTIVITY RESTRICTION FORM

(C or D)

Y

N

Inmate Name

Inmate Number

Misconduct No.

Cell Assignment

Lesley Warren

KH1544

3H02

**Behaviors – Check all that Apply**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pre-hearing Confinement           | <input type="checkbox"/> Sexual Comments/Gestures        | <input type="checkbox"/> Assaultive Toward Staff      |
| <input type="checkbox"/> Verbally Abusive                  | <input type="checkbox"/> Tampers w/ cell door/wicker     | <input type="checkbox"/> Assaultive Toward Inmates    |
| <input checked="" type="checkbox"/> Self Abusive Behaviors | <input checked="" type="checkbox"/> Threatens Self-Abuse | <input type="checkbox"/> Medical/Mental Health Issues |
| <input checked="" type="checkbox"/> Destroys Property      | <input type="checkbox"/> Contraband/Weapons(s)           | <input type="checkbox"/> Escape Attempt               |
| <input type="checkbox"/> Throws Body Fluid                 | <input type="checkbox"/> Feigning Medical Problems       | <input type="checkbox"/> Other _____                  |

**Approved Restrictions – Check all that Apply**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Exercise  | <input type="checkbox"/> Television                                 | <input checked="" type="checkbox"/> Restraint Chair* (8 hour maximum unless approved by the Facility Manager/designee) |
| <input type="checkbox"/> Shower  | <input type="checkbox"/> Secure Food Pass                           | <input type="checkbox"/> Movement Restrictions – Use of belt for exercise/showers/toilet                               |
| <input type="checkbox"/> Shave   | <input type="checkbox"/> Videotape of Movements                     | <input type="checkbox"/> Movement Restrictions – Use of tether for exercise/showers/toilet                             |
| <input type="checkbox"/> Cell Cleaning   | <input type="checkbox"/> Plexiglas Shield                           | <input type="checkbox"/> Movement Restrictions – Use of leg restraints for exercise/showers/toilet                     |
| <input type="checkbox"/> Spit Mask   | <input type="checkbox"/> Commissioned Officer present for movements |  |
| <input type="checkbox"/> Water   | <input type="checkbox"/> Mini Law Library                           |  |
| <input type="checkbox"/> Container   | <input type="checkbox"/> Radio                                      |  |
| <input type="checkbox"/> Commissary  |   |  |
| <input type="checkbox"/> Bedding Materials   |   |  |
| <input type="checkbox"/> In Cell Restriction – Use of handcuffs, treatment belt, and/or leg shackles (24 hour maximum unless approved by the Medical Department) |   |  |

Requested By:

Date: 10/21/15 Time: 1445

Shift Commander Signature/Date:

☒ Approved ☐ Disapproved

\*Restraint Chair – Name of Medical Staff Member/Date:

☒ Approved ☐ Disapproved

RN Nigh

Restriction Removed By:

Date: Time:

**No restriction may exceed 7 days unless approved by the Facility Manager/designee.**

Name/Title of approving authority: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Comments \_\_\_\_\_

cc: Facility Manager  
DSFM  
DSCSShift Commander/Captains Office (original)  
DSIS (If applicable)  
Intelligence CaptainDC-14  
DC-15  
RHU Control Room**6.5.1, Administration of Security Level 5 Housing Units****Section 1 – Administration**Issued: 2/7/2014  
Effective: 2/14/2014**Attachment 1-L****Req 3-DEF000715**



SCI Frackville		EOR #		2015-Frackville	
DESCRIPTION OF INCIDENT					
Chair Placement Inmate KA-1544 Easley, Warren					
DATE:	10/21/15	TIME:	1448		
INMATE NAME: (LAST, FIRST)			DC NUMBER:		
Easley Warren			KA 1544		
Photo of Area :			Face		
STAFF MEMBER :			CO1 Scarpati		





SCI Frackville

EOR #

2015-Frackville

## DESCRIPTION OF INCIDENT

Chair Placement Inmate KA-1544 Easley, Warren

DATE:

10/21/15

TIME:

1448

INMATE NAME: (LAST, FIRST)

DC NUMBER:

Easley Warren

KA 1544

Photo of Area :

Right Wrist

STAFF MEMBER :

CO1 Scarpati

Req 3-DEF000717



10.21.2015 14:49

SCI Frackville		EOR #		2015-Frackville	
DESCRIPTION OF INCIDENT					
Chair Placement Inmate KA-1544 Easley, Warren					
DATE:	10/21/15	TIME:	1449		
INMATE NAME: (LAST, FIRST)			DC NUMBER:		
Easley Warren			KA 1544		
Photo of Area :			Left Wrist		
STAFF MEMBER :			CO1 Scarpati		

Req 3-DEF000718





10.21.2015 14:49

SCI Frackville	EOR #	2015-Frackville
DESCRIPTION OF INCIDENT		
Chair Placement Inmate KA-1544 Easley, Warren		
DATE:	10/21/15	TIME: 1449
INMATE NAME: (LAST, FIRST)		DC NUMBER:
Easley Warren		KA 1544
Photo of Area :		Ankles
STAFF MEMBER :		CO1 Scarpati

Req 3-DEF000719